Account #: _____

Doctors Care
Affordable and Accessible Health Care

Please answer these private questions.
You information is safe. We update this information every year.

PATIENT/CLIENT INFORMATION

First & Last Name:		Name You Want to Be Called (if different):
DOB:	Sex at Birth: ❑ Male ❑ Female	Pronouns: ❑ She/Her/Hers ❑ He/Him/His ❑ They/Them/Theirs

Gender Identity: ❑ Male ❑ Female ❑ Trans-Male ❑ Trans-Female ❑ Non-Binary ❑ Other: _____ ❑ Refuse to Answer

Sexual Orientation: ❑ Straight ❑Lesbian/Gay ❑ Bisexual ❑ Unknown ❑ Other: _____ ❑ Refuse to Answer

Home Phone:	Cell:	Patient/Client Cell if age 12-17:

Street Address: Apt., Suite Number (Optional):

City: State: Zip Code:

County: ❑ Adams ❑ Arapahoe ❑ Denver ❑ Douglas ❑ Elbert ❑ Jefferson ❑ Other: _____

Email Address:	**Clinic Patients Only*:** Sign up for the Patient Portal? ❑ Yes ❑ No **Must be 18 years and older to access the Patient Portal*

Marital Status: ❑ Married ❑ Partner ❑ Divorced ❑ Single ❑ Widowed ❑ Legally Separated

IF PATIENT IS 18 YEARS AND UNDER (Child/Minor), PLEASE FILL OUT:

Responsible Party Name: _____
Relation to Patient/Client: ❑ Parent ❑ Grandparent ❑ Legal Guardian ❑ Other: _____

2nd Parent/Guardian Name: _____ 2nd Parent/Guardian Phone: _____
Relation to Patient/Client: ❑ Parent ❑ Grandparent ❑ Legal Guardian ❑ Other: _____

EMERGENCY CONTACT INFORMATION

Name:	Relation:	Home:	Cell:

CONTACT CONSENT

Who can we talk to? Your/your minor's health information is confidential and protected by Doctors Care. If you want us to talk with someone else (spouse, child, parent, etc.) about your/your minor's information, list them below.

❑ **No**, I do not allow information to be shared with anyone at this time.

❑ **Yes**, I give permission to Doctors Care to release my/my child's protected health information (lab results, medication, other health related information, etc.) to the following person:

Name:	Relation:	Phone:

Doctors Care can share my/my minor's information to those listed. This is not a consent to treatment. It does not allow someone to take my place with a minor at a visit. I can change or cancel this release at any time. This consent will expire in 1 year.

SIGN HERE

Signature (Parent/Guardian if Minor) Date

➡ OVER

INCOME INFORMATION (FOR GRANT PURPOSES)

Doctors Care is a non-profit that **depends on grants to serve you**. Some grants require income information. **The information is kept anonymous.** For our uninsured patients, we use this information to offer services at a low-cost sliding fee.

Total Income in Your Household Monthly: OR Yearly:

Number of People That Live in Your Home:	**Number of People (Including You) on Your Taxes:**

DEMOGRAPHIC INFORMATION (FOR GRANT PURPOSES AND QUALITY OF CARE)

(Please Answer All Questions for the Patient/Client)

Preferred Language: ❑ English ❑ Spanish ❑ Other:

Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic

Race (Select all that apply):

❑ White ❑ Black/African American ❑ Native Hawaiian/Pacific Islander ❑ Middle Eastern/North African ❑ Asian

❑ Native Hawaiian/Pacific Islander ❑ American Indian/Alaska Native ❑ Other:

Does the patient/client have a disability? ❑ Yes ❑ No	Is the patient/client a Veteran? ❑ Yes ❑ No

HEALTH INSURANCE INFORMATION

Coverage Type: ❑ Medicaid/CHP+ ❑ Uninsured ❑ Private Insurance ❑ Other:

If you selected Uninsured, would you like getting help enrolling in health insurance? ❑ Yes ❑ No

LIFE CHANGE EVENTS: If you have health insurance and experienced a life change event in the last 60 days, you may be eligible to make changes to your coverage. Doctors Care's Health Coverage Guides can help you update your PEAK or Connect for Health account. Please let us know if you have experienced any of the following:

❑ Moved	❑ Had a baby	❑ Lost your health insurance	❑ Married/Divorced
❑ Change in Income or Job	❑ Became a Legal Resident	❑ Left incarceration	❑ Starting/Ending AmeriCorps

PHARMACY INFORMATION: We e-Prescribe – No Paper! (Clinic Patients Only)

Pharmacy Name:	Phone Number:

Address/Cross Streets:

APPOINTMENT INFORMAITON

How did you make your appointment?

❑ By Phone ❑ Walk-In ❑ Email ❑ Online ❑ Connect for Health Colorado Website ❑ Other:

How did you hear about our services?

❑ Connect for Health Colorado ❑ Medicaid/CHP Provider Website ❑ Internet Search ❑ Neighbor/Friend

❑ Drove By/Saw Sign ❑ Direct Mail (Postcard or Letter) ❑ Current Patient/Client ❑ Social Media ❑ Other: _____

❑ County Office (Please Specify):	❑ Doctor Referral (Please Write Name):	❑ Hospital/ER (Please Provide Name):
_____	_____	_____
❑ Event (Please Specify):	❑ School (Please Write Name):	❑ Other Organization (Please Specify):
_____	_____	_____